Informed Consent and Disclosure Statement for Counseling and Psychotherapy Services

LiveWell Counseling, LLC

Welcome to LiveWell Counseling, LLC. I believe it is essential to have clarity when establishing a psycho-therapeutic relationship. The therapist and client each have clearly defined rights and responsibilities that, when followed, provide the support necessary for trust, empowerment, and growth. Please read the following information to be well-informed about my policies and your client rights:

Services Provided: I provide Mental Health Counseling to teens, adults, and couples, integrating a number of different therapeutic modalities dependent on client needs. Some of the therapeutic models I use include EFT couple therapy, IFS, Cognitive-Behavioral Therapy, Motivational Interviewing and Lifespan Integration. My approach to therapy is holistic, client-centered, and humanistic.

Diagnosis: If a third party (insurance company) pays LiveWell Counseling, LLC or reimburses you for counseling services, I am required to give a diagnosis to that third party. You may contact me with any questions about your diagnosis.

Fees: Initial Intake sessions are $150. Continuing sessions are $130 per 50-minute session. I require a 24-hour notice to avoid a $75 charge. Phone calls or consultation appointments greater than 10 minutes will be charged at 15-minute increments based on the hourly fee. Under special circumstances I may arrange a reduced fee for you. Please inform me of any financial concerns that may prohibit continuing therapy. I do accept commercial insurance and am currently under contact with Anthem, Cigna, and Husky. Per insurance contracts, clients are responsible for their co-pays and deductibles at the time services are rendered. As a general rule, if you are behind in payment for 3 sessions, I will place a hold on our meetings until you have met your financial obligations. You are not liable for any fees or charges for services rendered prior to the receipt of the disclosure statement.

Payment: I accept cash, checks. HSA cards, and credit cards. There is a $25 fee for any returned check.

Office Structure: My office is located within a suite of offices which I share with other therapists. I am, however, an independent practitioner and share office space based on mutual professional interests. Please be respectful of other clients and of building policies (COVID policy currently in effect).

Scheduling Sessions: We can schedule appointments via phone, email or in person at the end of a session. We can also schedule a standing appointment. I generally recommend 45-60 minute sessions be scheduled each week to support the continuity and depth of our work together. Other need-based arrangements can also be made.

Termination of therapy: Completion is an essential part of the process. Ideally, we should take 1-3 sessions to conclude our work. However, if you find at any time, that this therapeutic process is not meeting your needs, you have a right to request adjustments and/or to discontinue treatment. If more than 60 days have passed since our last client contact, I will accept that as your notice of termination.

Confidentiality: Information exchanged in my office is held in the strictest confidence and no information can be released without your written permission with certain exceptions. I am required by law to break confidentiality when a client poses a threat to self or others; there I suspected abuse of a child, elder or mentally disadvantaged person; and/or in response to a subpoena. I hope these situations do not arise but if they do, I will need to contact the appropriate authorities and/or your emergency contact.

Case Consultations: To provide quality care, I may review your case with a consultant following the guidelines of confidentiality to protect your identity. Consultation with colleagues helps me to provide the best counseling service to you.

Email policy: Although email is convenient for me and the client, please be aware that electronic mediums such as email are not always secure, and I cannot guarantee confidentiality. Please know that emails will be returned within 48 hours. If you need a faster response, please leave a message at: 860-690-9961. If you are experiencing an emergency, please see the Emergency protocol below.

My availability and Emergency Procedures: A message my be left on my voicemail at any time and I will do my best to return the phone call within 48 hours. If you do not hear back within 48 hours, please feel free to call back as occasionally messages are not properly recorded or inaudible. If you are experiencing an emergency, please clearly indicate that it is an emergency and leave a phone number where I may reach you. In a crisis, you may need assistance before I am able to return your call. Please call 211 (crisis intervention) or 911 if you need immediate help. You may also contact your local emergency department for help. I will be sure to let you know when I am going to be unavailable such as the case with conferences and/or vacations. If necessary, I can arrange for a therapist to be a point of contact in my absence.

Other rights: You always have the right to ask questions about anything that happens in therapy. I am always willing to discuss my thoughts about how to achieve your goals, and to look at alternatives that might work better. I am happy to share information about my background, education and training at your request.

Complaints: If you have a complaint about my professional service, I hope that you will feel comfortable speaking to me directly so the problem can be resolved. However, you have the right to file a complaint with the Connecticut State Department of Public Health if you believe you are the victim of professional misconduct. You may call 860-509—7552, email: dph.pliscomplainsts@ct.gov or at: 410 Capital Avenue, MS #12HSR, Hartford, CT 06134-0308.

1. ____ I have read the Psychotherapy Information Disclosure Statement, have had sufficient time to be sure that I considered it carefully, asked any questions that I needed to in order to fully understand it.
2. ____ I consent to the use of a diagnosis for insurance billing, and to release of that information and other information necessary to complete the insurance billing process.
3. ____ I have reviewed a copy of the "Notice of Policies and Practices to Protect the Privacy of Health Information."
4. ____ I acknowledge that I am responsible for paying for my therapy. I agree to pay the fee at the time of session, or to pay the stipulated co-pay if I am covered by insurance, or the missed appointment/late cancellation fee. I acknowledge that if I do not provide required payments, LiveWell Counseling, LLC, has the right to utilize a collection agency to obtain the balance.
5. ____ I consent to allow LiveWell Counseling, LLC to consult with professional peers for confidential supervision concerning my therapy.
6. ____ I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with LiveWell Counseling, LLC. I know I can end therapy at any time

Signed Name:_____

Printed Name:_____Date:_____